United States General Accounting Office

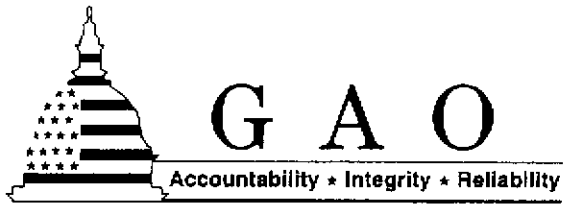
GAO

Performance and Accountability Series

January 2003

# Major Management Challenges and Program Risks

## Department of Health and Human Services




GAO-03-101

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# Highlights

Highlights of GAO-03-101, a report to Congress included as part of GAO's Performance and Accountability Series

PERFORMANCE AND ACCOUNTABILITY SERIES

# Department of Health and Human Services

## Why GAO Did This Report

In its 2001 performance and accountability report on the Department of Health and Human Services (HHS), GAO identified key management challenges faced by HHS and its constituent agencies associated with the Medicare program, oversight of nursing homes, medical product safety and efficacy, and ensuring the well-being of children and families. The information GAO presents in this report is intended to sustain congressional attention and a departmental focus on continuing to make progress in addressing these challenges—and others that have arisen since 2001. This report is part of a special series of reports on governmentwide and agency-specific issues.

## What Remains to Be Done

HHS's management challenges remain as profound as they are diverse: the effective management of the Medicare and Medicaid programs has significant fiscal implications for the longer term, while strengthening the nation's public health infrastructure is critically important in the shorter term. HHS must further strive to obtain current and reliable data for effective program monitoring, conduct well-targeted oversight activities to safeguard billions of program dollars, and hire and retain a sufficiently skilled workforce.

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To view the full report, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

## What GAO Found

**Medicare program.** Medicare remains on GAO's 2003 list of high-risk programs due to the program's size and complexity. The Centers for Medicare & Medicaid Services (CMS) continues to have difficulty refining Medicare's payment methods in ways that reward fiscal discipline while ensuring beneficiary access to care. Since 2001, the agency has made progress in estimating improper payments, collecting overpayments and conducting other financial activities, and identifying information system needs, but further improvements are needed in payment safeguard, financial, and information management activities.

**Medicaid program.** GAO has added Medicaid to its 2003 list of high-risk programs, owing to the program's size, growth, diversity, and fiscal management weaknesses. Limited oversight has afforded states and health care providers the opportunity to increase federal funding inappropriately.

**Medicare and Medicaid care oversight.** CMS has taken steps to improve nursing home oversight, but efforts to ensure quality care at nursing homes, home health agencies, kidney dialysis facilities, and other providers continue to be jeopardized by problems in the performance of state inspections, complaint investigations, and enforcement of federal standards.

**Public health emergency preparedness.** Serious problems in coordination among federal, state, and local public health agencies and in hospital and laboratory capacity could limit emergency responses. HHS is also challenged to balance basic public health needs with critical homeland security priorities.

**Medical product safety and efficacy.** While the Food and Drug Administration has stepped up the rigor of its biologics inspections, it faces several challenges in ensuring the availability, safety, and efficacy of marketed products, including vaccines, and struggles to retain its expert staff.

**Economic independence and well-being of children and families.** Oversight by HHS of the states' implementation of social service program reforms has been encumbered by limitations in states' information systems, program effectiveness measurement, and efforts to foster and disseminate research findings.

**Financial management systems, processes, and controls.** HHS has improved its financial management, but its systems and processes do not routinely generate financial information that is timely or reliable. Further, HHS cannot ensure that it can protect the confidentiality of sensitive information from unauthorized access or its systems from service disruption.

Over the years, the agency repeatedly proposed legislation to obtain new contracting authority and flexibility. In June 2001, we testified that Medicare could benefit from Congress removing CMS's contracting limitations and from use of full and open competition in the selection of claims administration contractors.[19] In June 2002, the U.S. House of Representatives passed a bill that would amend the Medicare statute to require competitive contracting and allow CMS greater flexibility in its contracting arrangements.

Should CMS be granted more flexible contracting authority that relies on competition, effectively managing the transition to a different contracting environment will be a major new challenge for the agency in the coming years. As we reported in our 2001 assessment of high-risk federal programs, federal agencies that manage large procurements of contracted services—such as the departments of Energy and Defense—have had difficulties with contract acquisition and management.[20] These have included problems such as cost and schedule overruns and failure to oversee contractors and hold them accountable. CMS would need to carefully plan and manage its own contracting efforts, while being attentive to best practices in the field, to avoid some of the pitfalls experienced by other agencies.

## Enhance the Fiscal and Management Oversight of the Medicaid Program

Medicaid is a program jointly funded by the federal government and the states that pays for both acute health care and long-term care services for over 44 million low-income Americans, about half of whom are children and over one-quarter of whom are aged, blind, or disabled. The program's day-to-day administration is conducted by the states and is overseen at the federal level by CMS in HHS. The challenges inherent in overseeing a program of Medicaid's size, growth, and diversity, combined with the open-ended nature of the program's federal funding, puts the program at high

[19] U.S. General Accounting Office, *Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services*, GAO-01-918T (Washington, D.C.: June 28, 2001). Also see U.S. General Accounting Office, *Medicare: Comments on HHS' Claims Administration Contracting Reform Proposal*, GAO-01-1046R (Washington, D.C.: Aug. 17, 2001) and U.S. General Accounting Office, *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity*, GAO/HEHS-99-115 (Washington, D.C.: July 14, 1999).

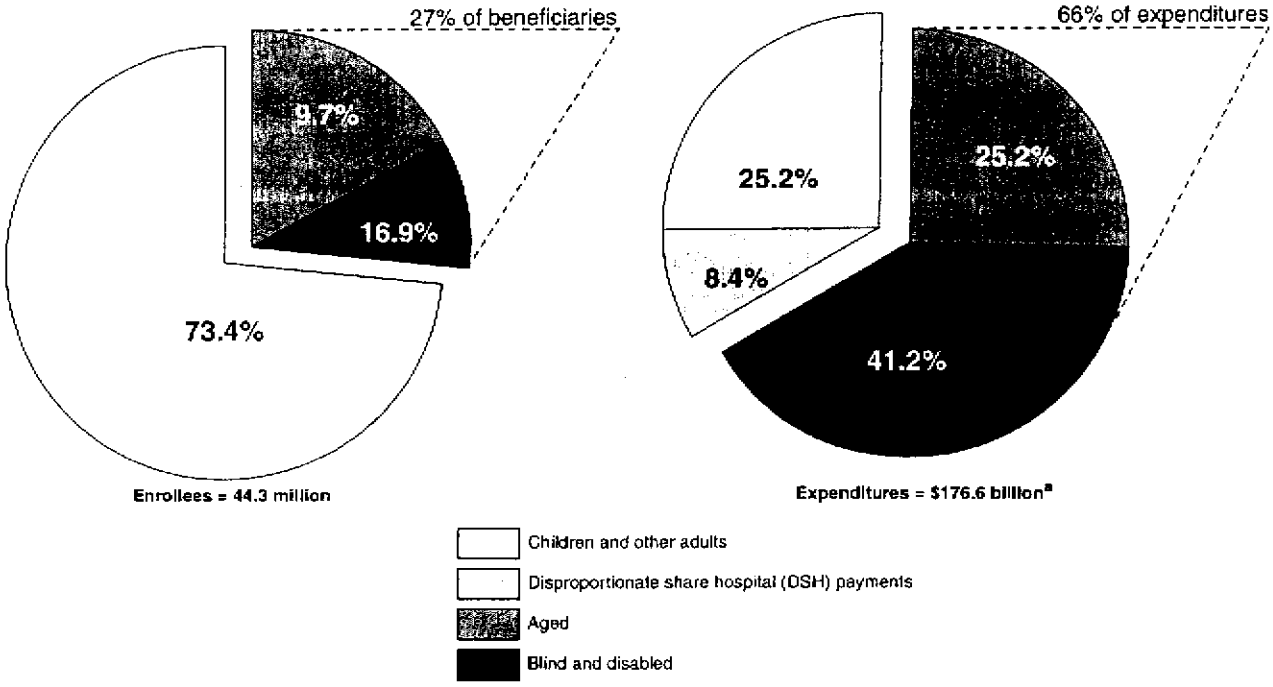
[20] U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-01-263 (Washington, D.C.: January 2001).

risk for waste and exploitation and we have added Medicaid to our 2003 list of high-risk programs. Consider the following program characteristics:

- *Size.* In fiscal year 2001, federal and state Medicaid expenditures totaled $228 billion. The federal share was about 57 percent, representing 7 percent of all federal outlays. Medicaid is the third largest social program in the federal budget (after Social Security and Medicare) and the second largest budget item for most states (after education), accounting for about 20 percent of states' total expenditures.

- *Growth.* The Congressional Budget Office projects that Medicaid spending will grow each year on average by 8.8 percent, which would more than double total Medicaid spending in 9 to 10 years. Recent Medicaid expenditure growth has been fueled in part by escalating prescription drug and hospital costs, as well as by "creative" state financing schemes that inappropriately increase the federal share of Medicaid expenditures without increasing the states' contribution. Future program spending will also be significantly affected by the growth of the population aged 65 and older, which is expected to more than double by 2040. Individuals who are aged, blind, or disabled already incur significantly higher Medicaid expenditures than those in other eligibility categories. These individuals represent 27 percent of all Medicaid beneficiaries, but they account for 66 percent of expenditures, as shown in figure 1. As the share of the population that is aged grows, so too will associated long-term care expenditures, thus exerting additional financial pressures on future federal and state budgets.

**Figure 1: Medicaid Expenditures Are Disproportionately for Individuals Who Are Aged, Blind, or Disabled**




Source: CMS enrollment and expenditure data, fiscal year 2000, the most recent year for which data are available by type of beneficiary.

[a]Total Medicaid fiscal year 2000 expenditures were $209.6 billion; expenditures in the figure do not include administrative expenses ($10.6 billion) and other expenses that could not be attributed to particular beneficiary populations.

- *Diversity.* Within broad federal guidelines, states have considerable flexibility in how they administer their Medicaid programs. Each state determines the amount, duration, and scope of covered services; establishes eligibility guidelines; sets payment rates; and develops its own administrative and delivery system structure. While federal statute requires states to cover certain populations and services under Medicaid, states may choose to expand eligibility or add benefits that the statute defines as optional.[21] About two-thirds of total Medicaid expenditures are attributable to services for optional populations and benefits. The resulting variation across states in populations covered and benefits offered makes Medicaid less like a single program than like 56 separate programs—the 50 states, the District of Columbia, Puerto Rico, and U.S. territories—thus posing significant complexities for federal oversight.

- *Open-ended federal funding.* Under Medicaid, the federal share of each state's expenditures, also called the federal match, is based on a formula that is linked to each state's per capita income and its total program spending. The federal liability for program expenditures is open-ended, as there is no limit on state spending for services that are covered under a CMS-approved state Medicaid plan. In 2001, the federal shares ranged from 50 to 77 percent of a state's total Medicaid expenditures.

Our concerns about the program's risks have been heightened by our work in recent years, which confirms the program's vulnerability to exploitation and mismanagement. Through this work we have identified key problems, including

- schemes by some states to inappropriately leverage federal funds,

- state waiver programs that inappropriately increase the federal government's financial liability, and

- insufficient federal and state oversight to ensure that payments to health care providers are accurate and appropriate.

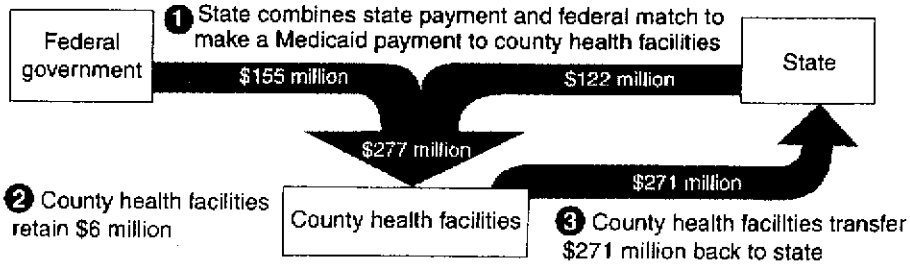
[21] Mandatory services include inpatient and outpatient hospital care; physician services; nursing home care; lab and x-ray services; immunizations, and other early and periodic screening, diagnostic, and treatment services for children; family planning services; health center and rural health clinic services; and nurse midwife and nurse practitioner services. Services that are optional include outpatient prescription drugs, institutional care for persons with mental retardation, personal care, and dental and vision care for adults.

We have also identified consistent weaknesses with federal oversight of the quality of care in nursing homes, which receive billions of dollars annually in Medicaid funds. These issues are addressed in a separate section in this report entitled "Improve Oversight of Care Delivered to Medicare and Medicaid Beneficiaries."

## State Financing Schemes Often Inappropriately Increase Federal Medicaid Payments

For more than a decade, states have used various financing schemes to inappropriately generate excessive federal Medicaid matching funds while their own share of expenditures has remained unchanged or decreased. Using statutory and regulatory loopholes, some states have created the illusion that they have made large Medicaid payments to certain providers, such as county health facilities, in order to generate federal matching payments. In reality, generally through electronic funds transfers, the states have only momentarily made payments to these providers, as states have required the payments to be returned. In some cases, states have used these federal payments for purposes other than Medicaid. Figure 2 illustrates a financing arrangement under which a state can inappropriately increase federal matching funds with no outlay of state funds.

**Figure 2: One State's Arrangement to Increase Federal Medicaid Payments Inappropriately**




Source: GAO analysis.

In figure 2, a state makes Medicaid payments totaling $277 million to certain county health facilities; the total includes $155 million in federal funds at a matching rate of 56 percent (step 1). On the same day that the county health facilities receive the funds, they transfer all but $6 million of the payments back to the state, which retains $271 million—a net gain of $149 million over the state's original outlay of $122 million (steps 2 and 3).

Although the Congress and CMS have repeatedly acted to curtail abusive financing schemes when they have come to light, states have consistently developed new variations to this basic approach. Each variant has the same result: the state's share of program expenditures is shifted to the federal government, while federal Medicaid payments escalate, with no assurances that the excessive federal payments are used for valid Medicaid expenditures for covered beneficiaries. Table 2 describes various abusive Medicaid financing arrangements used by states and the actions taken by the Congress and CMS to curtail them.

**Table 2: Federal Actions to Address Inappropriate State Financing Arrangements**

| Financing arrangement | Description | Action taken |
|---|---|---|
| Payments to state health facilities | States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasury. | In 1987, HCFA issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states. |
| Provider taxes and donations | Revenues from special taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers, which returned most of the federal payment to the state. | The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially banned provider donations and placed a series of restrictions on provider taxes. |
| Disproportionate share hospital (DSH) payments | DSH payments compensate hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which returned the bulk of the state and federal payments to the state. | The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and that individual hospitals could receive. |
| DSH payments to state mental hospitals | A large share of state DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasury. | The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals. |
| Payments to local government health facilities | In an effort to ensure that Medicaid payments are reasonable, the federal statute and regulations prohibit Medicaid from paying more than what Medicare would pay for comparable services. This upper payment limit (UPL) applies to total payments and not individual services. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the state. | The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals. |

Source: GAO analysis.

Financing schemes that some states use to inappropriately generate federal payments can spread quickly to other states. For example, from 1990 to

1992, payments that compensate hospitals that care for a disproportionate number of low-income patients—called DSH payments—spiked from $1 billion to over $17 billion. After limits were put on DSH payments, states found that they could exploit the upper payment limit (UPL) on Medicaid payments to conduct other financing schemes. From 1999 to 2000, the number of states using UPL-related schemes grew from 12 to 28, accounting for an estimated $5.8 billion in excessive federal payments.

The savings estimated to result from curbing states' exploitative practices demonstrate the enormous impact state financing schemes can have on the federal budget. Prompted by our testimony,[22] CMS's 2001 regulation reducing the federal government's financial liability under the UPL provision is estimated to save $55 billion over 10 years, and the related 2002 CMS regulation is estimated to yield an additional $9 billion over 5 years.

While the Congress and CMS have often acted promptly to address Medicaid financing schemes once they become apparent, new variations continue to emerge and recommendations to reduce problems remain open. Consequently, we recommended that the Congress consider legislation to prohibit making Medicaid payments to a government-owned facility that exceed the facility's costs. Additionally, CMS has responded, in part, to recommendations made by OIG regarding UPL-related payments, but CMS requirements do not provide for the capture of information to determine whether local government health facilities transfer the federal funds they receive back to the state.

States that have relied on abusive practices to maximize federal funds as a staple for state financing are feeling the budgetary pressure from the loss of these funds. Experience shows that some states are likely to look for other creative means to supplant state financing, making a compelling case for the Congress and CMS to sustain vigilance over federal Medicaid payments.

## Waiver Demonstration Programs May Increase Federal Liability for Program Expenditures

HHS oversight responsibilities include ensuring that states' demonstration programs do not put the federal government at risk for spending more on Medicaid than it would without such programs. The Secretary of HHS has broad authority under section 1115 of the Social Security Act to waive certain statutory provisions and allow states to conduct Medicaid research

[22] U.S. General Accounting Office, *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, GAO/T-HEHS-00-193 (Washington, D.C.: Sept. 6, 2000).

and demonstration projects that test new ideas for delivering services and covering more people. Specifically, HHS can grant section 1115 waivers to provide federal funds for services and populations not otherwise eligible for federal matching payments. States have commonly used section 1115 waivers to provide health care coverage to Medicaid beneficiaries by enrolling them in managed care plans. An estimated 20 percent of all Medicaid funds are now spent under section 1115 waivers. Historically, HHS and the Office of Management and Budget (OMB) have required that the demonstration projects be budget neutral—that is, the demonstration's cost to the federal government should be no more than it would have been without the waiver.

Since the mid-1990s, however, adherence to budget neutrality requirements has eroded, as HHS and OMB have permitted states to use questionable methods that in our view do not demonstrate budget neutrality. The section 1115 waivers of two states, approved in 2002, are estimated to cost the federal government at least $330 million more than if the waivers had not been approved. For one state's waiver, HHS and OMB continued a practice that we first identified and objected to in 1995, which allows states to disregard substantial new costs that would be incurred under the waiver, thus making it easier to demonstrate budget neutrality. For the other state's waiver, HHS and OMB allowed the state to include impermissible costs to raise the level of costs estimated without the waiver, thus making it easier to claim that the demonstration was budget neutral and, in turn, inflating the share for which the federal government would be liable. Our concern is that additional states have requested similar waivers that are currently under review. In 2002, we recommended that HHS ensure that only valid methods are used to demonstrate budget neutrality,[23] but the department and OMB continue to allow states to disregard significant amounts of waiver costs when demonstrating budget neutrality.

[23] U.S. General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

## Shortcomings in Routine Oversight and Financial Management Practices Leave Program Dollars Ill-Protected

One of CMS's major challenges is to balance state flexibility with accountability by providing adequate oversight of states' Medicaid financial transactions. Our work shows that CMS falls short in providing the level of oversight required to ensure accountability. In particular, CMS lacks important policies and procedures to guide either its own or states' financial oversight activities, and it has not provided consistent guidance to the states on appropriate payment practices.

Our studies of federal and state agencies' controls over payments have identified systemic weaknesses in both federal and state oversight of Medicaid expenditures.[24] Our February 2002 report on federal oversight of state claims for reimbursement found that CMS's general policies and systems for financial oversight of state Medicaid programs were limited. For example, CMS did not (1) have a sound method for identifying areas at high risk for improper payments, (2) have performance standards for review of state expenditures, or (3) conduct analyses of trend information on the amount and type of Medicaid expenditures deferred or disallowed to monitor performance of this oversight activity. To address these weaknesses, we recommended a range of approaches to strengthen internal controls and target limited resources. In response, CMS has initiated steps to improve financial reviews of Medicaid, which are in the planning and early implementation stages.

In examining states' controls over improper payments to providers, we found that states' efforts to identify billing errors and abusive billing practices have been generally limited and only modestly funded. In our June 2001 review, half the states reported spending no more than one-tenth of 1 percent of program expenditures on activities to safeguard program payments. No state had requested the full amount of federal funds available for antifraud efforts because they would have had to increase their own spending to receive the full federal match.

The potential benefit of improving oversight has been demonstrated by individual state efforts. In our June 2001 study, we reported that, since July 1999, California had identified $58 million in fraudulent billings by 115 providers and pharmaceutical and durable medical equipment wholesalers

[24] U.S. General Accounting Office, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed*, GAO-02-300 (Washington, D.C.: Feb. 28, 2002), and U.S. General Accounting Office, *Medicaid: State Efforts to Control Improper Payments Vary*, GAO-01-662 (Washington, D.C.: June 7, 2001).

and suppliers; it was investigating an additional 300 entities for suspected fraud that could exceed $250 million. Kentucky's analysis of claims payment data identified $137 million in overpayments to providers between January 1995 and June 1998.

Our review of certain Medicaid services provided to children through their schools also demonstrates the importance of heightened scrutiny over Medicaid expenditures.[25] In one state alone, there were $324 million in disallowed claims involving school-based services for three-and-a-half years ending in fiscal year 2001.[26] Some claims were for services not covered by Medicaid or for services provided to non-Medicaid-eligible children. Our work also showed that, in some states, very little of the federal reimbursement went directly to schools where the services were provided. Some schools ended up with as little as $7.50 for every $100 that the state claimed for reimbursement, once states retained a portion of federal reimbursements and private consulting firms were paid contingency fees.

Our review of Medicaid reimbursement in schools further illustrated CMS's weaknesses in providing the states sufficient program guidance and oversight. Schools in some states conduct outreach for the Medicaid program and perform certain diagnostic, screening, and therapy services. States that provide school-based Medicaid services must establish procedures for determining Medicaid's payment rates within broad federal guidelines.[27] Under these procedures, the costs identified for schools' administrative services claims must be directly attributable to supporting the Medicaid program. Our analysis found that some CMS regions failed to (1) provide clear and consistent guidance to schools and state agencies or (2) exercise adequate controls over the approval of claims for school-based services. Our recommendations to CMS on school reimbursement were aimed at improving the agency's oversight and establishing more consistent policies about what constitutes appropriate payment. CMS has taken action to clarify reimbursement policies addressing administrative

[25] U.S. General Accounting Office, *Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight*, GAO/HEHS/OSI-00-69 (Washington, D.C.: Apr. 5, 2000).

[26] This fiscal year 2001 figure updates the findings in our April 2000 report.

[27] States must abide by the cost allocation principles described in OMB Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.

activities performed by certain medical personnel in schools. Additionally, CMS is developing more consistent guidance for its regions, states, and schools regarding what is allowable in submitting claims for reimbursement for school-based administrative costs from Medicaid.

## Improve Oversight of Care Delivered to Medicare and Medicaid Beneficiaries

CMS and the states share oversight responsibility for thousands of health care providers that deliver care directly to Medicare and Medicaid beneficiaries. (See table 3.) In response to congressional requests, in recent years we have reviewed oversight efforts for three of these types of providers—nursing homes, home health agencies, and kidney dialysis facilities—that provide critical and often life-saving care to nearly 4.5 million vulnerable individuals and that receive over $70 billion annually in Medicare and Medicaid payments. Providers become eligible for federal reimbursement for services provided by adhering to federal quality standards, including statutory, regulatory, and other requirements designed to help ensure that patients receive appropriate care or treatment and are protected from harm. To ensure that providers remain eligible for federal funding, CMS contracts with state agencies to conduct periodic inspections, called surveys, of the providers' services. CMS, in turn, is charged with overseeing the adequacy of states' activities in monitoring providers' performance.